Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PROCARE NEURO MONITORING SERVICES LLC
PO BOX 532620
HARLINGEN TEXAS 78553

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-7711-01

MFDR Date Received
July 12, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...charges have been denied due to-Payment is included in the allowance for another service/procedure. According to Texas Workers Compensation Commission (TWCC), Rule 134.202-Letter B (Adoption Preamble for New §134.202 Medical Fee Guideline), TWCC had adopted the fee schedule from Medicare. According to Medicare Guidelines, Medicare Physician Fee Schedule Data Base (MPFSDB), the following CPT codes are ACTIVE CODES and are paid separately under the physician fee schedule under multiple modifiers."

Amount in Dispute: $1,802.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute concerns DOS 4/20/2007. Total amount in dispute appears to be $1476.00. Carrier has denied reimbursement for these services on the basis that the provider's services are reimbursed under another CPT code that has previously been reimbursed. Provider has already been reimbursed $101.00 for CPT code 51785, which covers the HCP's services entirely. Provider is not entitled to additional reimbursement at this time."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2007	Professional services rendered in an Inpatient Setting	$1,802.00	$229.63

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute resolution for which the Dispute resolution requests filed on or after January 15, 2007.

2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 21, 2007 and June 21, 2007
   - 97 – Payment is included in the allowance for another service/procedure
   - 1 – This procedure is included in another procedure performed on this date
   - 2 – Supplies and materials included in the procedure
   - * – Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution.

Issues

1. Did the requestor bill for services provided on the same day that are considered bundled by Medicare?
2. Did the requestor appropriately document the use of modifier -59?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for the HCPC code A4290 that is unvalued by Medicare?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for date of service December 23, 2003. CCI edits were generated off the CMS-1500 to identify any edit conflicts. Review of the CCI edits finds:
   - CCI Edit - Procedure 51785 and component procedure 95955 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement cannot be recommended for procedure code 95955.
   - CCI Edit - Procedure 95957 and component procedure 95920 are unbundled. The Standard Policy Statement reads "CPT Manual and CMS coding manual instructions". Reimbursement cannot be recommended for procedure code 95920.
   - CCI Edit – Procedure 51785 and component procedure 95925 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement cannot be recommended for procedure code 95925.
   - CCI Edit - Procedure 51785 and component procedure 95926 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement cannot be recommended for procedure code 95926.
   - CCI Edit - Procedure 51785 and component procedure 95927 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement cannot be recommended for procedure code 95927.
   - CCI Edit - Procedure 51785 and component procedure 95861 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement cannot be recommended for procedure code 95861.
   - CCI Edit - Procedure 51785 and component procedure 95900 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement cannot be recommended for procedure code 95900.
   - CCI Edit - Procedure 51785 and component procedure 95904 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement cannot be recommended for procedure code 95904.
   - CCI Edit - Procedure 95955 and component procedure 95957 are Unbundled. A modifier is not allowed. Reimbursement cannot be recommended for procedure code 95957.
   - Procedure Code A4557 is an item or service for which payment is bundled into payment for other physician services.
   - No CCI Edit conflicts were identified for CPT codes 95928, 95929 and A4290. Therefore these codes will be reviewed according to the applicable fee guidelines.

2. Review of the CMS-1500s indicates the requestor billed CPT code 97140 with modifier -59, for dates of service September 2, 2004, September 14, 2004, and September 16, 2004. The *CPT Manual* defines modifier -59 as follows**: Modifier -59:** "**Distinct Procedural Service:** Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries)not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used." Review of the submitted documentation finds:
    - The requestor billed the following procedure codes with modifier -59: 95920-TC-59, 95925-TC-59, 95926-TC-59, 95927-TC-59, 95861-TC-59, A4557-59 and A4290-59.
    - Review of the documentation submitted by the requestor does meet the documentation requirements for appending modifier -59 to the following CPT codes; 95920-TC-59, 95925-TC-59, 95926-TC-59, 95927-TC-59, 95861-TC-59, A4557-59 and A4290-59, therefore reimbursement cannot be recommended for the procedure codes noted in the previous sentence.
3. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection." Review of the documentation finds that:
    - Review of the Medicare and Texas Medicaid fee schedules did not contain a fee schedule amount for HCPC code A4290.
    - HCPC code A4290 is therefore subject to the provisions of 28 Texas Administrative Code §134.1.

    Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

    Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

    Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

    Former 28 Texas Administrative Code §133.307(c)(2)(G), applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
    - The requestor billed HCPC code A4290 on April 30, 2007.
    - HCPC code A4290 does not have an assigned value by Medicare or Texas Medicaid.
    - Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
    - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for HCPC code A4290.

- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Payment cannot be recommended for HCPC code A4290.

4. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%... (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule...." Review of the submitted documentation finds that:

   - The requestor billed and documented procedure codes 95928-TC and 95929-TC.
   - The -TC modifier identifies that the requestor provided the technical component of the procedure.
   - The CMS-1500 identifies that the requestor rendered professional services provided in an Inpatient hospital (place of service code 21).
   - CPT code 95928-TC x 1 unit: The Medicare rate for technical component is, $88.24 x 125% = MAR $110.30. Reimbursement in the amount of $110.30 is recommended.
   - CPT code 95929-TX x 1 unit: The Medicare rate for technical component is, $95.46 x 125% = MAR $119.33. Reimbursement in the amount of $119.33 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $229.63.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $229.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.